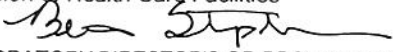


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9404	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2011
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, SPARTA			STREET ADDRESS, CITY, STATE, ZIP CODE 34 GRACEY ST SPARTA, TN 38583		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies No deficiencies were cited for complaint # TN 28533 under State Licensure 1200-8-6 Standards for Nursing Homes.		N 002		

Division of Health Care Facilities



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator

(X6) DATE

10-13-11

STATE FORM

6899

7R5711

If continuation sheet 1 of 1

OCT 13 2011